APPLICATION PROCESS AND PROCEDURES

To process a waiver request, two packets of information must be submitted:

- All information must be submitted AT THE SAME TIME.
- Submit ONE COMPLETE COPY of application along with the ORIGINAL application.
- Letters of need and forms must contain original signatures in the ORIGINAL application.
- Record the Case Number assigned by the Department of State on every sheet submitted
- Limit the use of staples, binders, or tabs. Avoid two-sided documents. Use only 8 1/2" x 11" paper

Both packets of information shall be mailed to:

Attn: J-1 Visa Waiver Review Program
State Primary Care and Rural Health Office, KDHE Bureau of Community Health Systems
1000 SW Jackson, Suite 340, Topeka, KS 66612-1365

Required Application Documents and Detailed Instructions

Documents shall be placed in the order detailed listed below separated by a colored divider page appropriately labeled with the name of the document behind it.

1) **Employer Cover Letter Requesting Waiver –** letter must following template provided
2) **Data Sheet DS-3035**
3) **Employment Contract**
   For further instructions, see "Physician – Employer Specific Contract Specifications" section Kansas J-1 Visa Program Policy and Procedures Manual
4) **Physician Exchange Visitor Attestation Form**
5) **DS-2019 Forms -** readable copies forms must be submitted, covering the full timeframe that the physician has participated in the exchange visitor program in J-1 status.
6) **U.S. Department of State Employer Attestation Form**
7) **Physician's Statement -** reason for not wishing to fulfill the two-year home country residence requirement to which he/she agreed at the time of accepting exchange visitor status.
8) **Physician's Current Curriculum Vitae**
9) **Explanation For Out of Status** – if physician applicant spent any period of time in some other visa status, out of status, or outside of the United States.
10) **Form G-28 or letterhead from law office -** if an attorney represents the applicant.
    Readable copies of documents/cards must be provided with the photocopies
11) **I-94 Entry and Departure Cards -** readable copies with the photocopies of the front and back on the same page.
12) **A "No Objection" Statement** – If foreign government funding was provided for the exchange visitor program.
13) **U.S. Department of State Exchange Visitor Attestation Form**
14) **Physician's KS Board of Healing Arts Medical license**
    If physician has not received official Kansas Medical License, the application should include copy of physician's medical license for state in which he/she is currently complete his/her residency program in.
    Note: If Kansas Medical License is not provided in application, a documentation must be provided with submission of the physician's initial Kansas Physician/Employer Reporting Form.
15) **Physician's Education Commission for Foreign Medical Graduates (**ECFMG) **certification**
16) **Recruitment Documentation**
    This section is <u>only</u> required for non-primary care physician applicants (i.e. Tier 2 or 3). For further instructions, see "Documentation of Recruitment Efforts" section Kansas J-1 Visa Program P&P Manual.
17) **Three (3) Signed Community Support Statements** (template/form)
    Must have at least one community support statement from a non-healthcare community leader AND one community support statement from a local physician, clinic, hospital, or health department <u>that is not employed or in the same system</u> as employer.
18) **Financial Assistance Policy, Discounted/Sliding Fee Schedule, and Application Documents**
    This section is <u>only</u> required for applicants applying for "FLEX" J-1 Visa Waiver slot.

Section 1:
Employer Cover Letter Requesting Waiver

Bureau of Community Health Systems
Office of Primary Care and Rural Health
1000 SW Jackson St., Suite 340
Topeka, KS 66612-1365

Kansas

Phone: 785-296-3135
Fax: 785-296-1231
primarycare@kdheks.gov
ruralhealth@kdheks.gov

Susan Mosier, MD, Acting Secretary | Department of Health & Environment | Sam Brownback, Governor

The Employer Cover Letter is a key resource for the Office of Primary Care and Rural Health in gathering information for program tracking purpose and communicating with leadership. In effort to increase efficiency in our review process and ease th streamline collection of information, the Office has created this cover letter template for applicant to follow:

Instructions

The Employer Cover Letter must be on the official letterhead of the employer and include the employer's business address, phone number, and other pertinent contact information.

Address the cover letter to the Office of Primary Care and Rural Health, Bureau of Community Health Systems, Kansas Department of Health and Environment, 1000 SW Jackson Street, Suite 340, Topeka, KS 66612.

The cover letter should follow the outline, using the exact subheadings listed below.

Introductory Sentence(s): The employer should keep the introduction to 1 to 2 sentences length. An example an introductory sentence is provided below:
"I am writing to request the Kansas Department of Health & Environment act as an interested government agency by making a recommendation to the Department of State's Waiver Review Division to grant a waiver of the two-year residence requirement pursuant to 8 U.S.C. 1182 (e) for Dr. (Insert physician's name), DOS # (Insert DOS Number)"

Subheading 1: "**PHYSICIAN APPLICANT INFORMATION"**

This section should include the following specific information about the physician:

a. Physician's date of birth;
b. Physician's place of birth and last legal residence;
c. Physician's medical specialty and residency specialization (if different);
d. Physician's National Provider Identification (NPI) number
e. Position Title and brief description of duties/responsibilities (approximately 2-4 sentences, no more than 100 words)
f. Salary

This section should also list the physical practice locations that the physician will be working at during his/her three-year contract agreement. A complete physical address including city and zip code should be provided,.

Subheading 2: "**DESCRIPTION OF EMPLOYER"**

This section should include brief description of the employer (no more than 250 words) and must include the following pieces of information:

a. Legal name and business address of employer
b. Other pertinent point of contact information.
c. Type of Organizational (i.e. private for-profit, public, private non-profit)
d. Brief description of the organization's primary service area (geographically)

Additionally, if employer is not directly the Kansas facility where the J-1 Visa physician will be practicing, written assurance must be signed by the employer and an authorized official with the Kansas facility/practice must be also provided with the cover letter.

Subheading 3: "**DOCUMENTATION OF RECRUITMENT EFFORTS"**

The employer must show evidence of open recruitment. This section should only include the following:

a. Length of time the entity has actively recruited for this position.
b. Entity's current staffing levels in the specialty – number physicians employed and number of position open.
c. Local, regional, and national venues utilized to advertise the open position
d. The number of applicants have applied and interviewed for the position
e. Indicate if any non J-1 physicians were offered the position and declined
f. Indicate if any non J-1 physicians were interviewed and **not** offered the position. If yes, provide details of each US worker interviewed and the reasons an offer was not extended.

For non-primary care specialty physician (i.e. Tier 2 or 3), proof of regionally and nationally advertising is also required and should be included in Attachment 16. For further instructions, see "Documentation of Recruitment Efforts" section Kansas J-1 Visa Program P&P Manual.

Subheading 4: "**DOCUMENTATION OF UNMET NEED FOR HEALTH CARE SERVICES"**

This section is required for all non-primary care specialty (i.e. Tier 2 or 3) physicians and/or if the employer is requesting a FLEX waiver slot. The following pieces of information must be provided:

- Description the community/population served by the facility or clinical site(s). Specified the approximate percentage of the population/patients seen by employer in its defined primary service area for each category listed:
    a) Recipients of KanCare/State publicly funded assistance
    b) Medicare beneficiaries
    c) Uninsured
    d) Low income (at/below 200% FPL)
- Quantifiable information the insufficient capacity of existing resources (locally or regionally) to meet the needs of the defined service area or underserved population.
    a) Current specialist to patient ratio
    b) Desired specialist to patient ratio:
    c) Explain any staffing changes justifying the need for the physician's services (i.e. changes in staffing due to retirement, increased referrals, etc.):
- (if applicable) Statement(s) regarding compliance requirements of accrediting bodies or state and national program guidelines in which the not filling of the vacant position will impact.

Waiver for Tier 3 specialty physician position must also describe the consequences to the employer and the treatment of low income patients if physician is not approved for a waiver. At a minimum, two the below informational items should be addressed in the employer's case for the unmet needs in the defined service area or underserved population.

- The population to specialist ratio supporting the defined service area or underserved population (or other measures of underservice for the service area)
- Utilization data (e.g. number of procedures most commonly performed by specialty being recruited).
- Waiting times for referrals from safety net providers
- Estimate the percent of time the physician will spend providing inpatient care vs providing outpatient care.

Section 2:
Data Sheet DS-3035

Section 3:
Employment Contract

Section 4:
Physician Exchange Visitor Attestation Form

Kansas Department of Health and Environment
J-1 Visa Waiver Program

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
STATE 30 J-1 VISA WAIVER PROGRAM AFFIDAVIT AND AGREEMENT

I, (please print**) _____, being duly sworn, hereby request that the Kansas Department of Health and Environment review my application for the purpose of recommending waiver of the foreign residence requirement set forth in my J-1 visa, pursuant to the terms and conditions as follows:**

1. I understand and acknowledge that the review of this request is discretionary and that in the event a decision is made not to grant my request, I hold harmless the State of Kansas, the Kansas Department of Health and Environment, the Bureau of Community Health Systems and any and all State of Kansas employees, agents, and assignees, from any action or lack of action made in connection with this request.

2. I further understand and acknowledge that the entire basis for consideration of my request is the Kansas Department of Health and Environment voluntary policy and desire to improve the availability of health care in medically underserved areas and to populations with unmet needs.

3. I understand and agree that in consideration for a waiver, which eventually may or may not be granted, I shall render medical care services to patients, including the medically indigent, for a minimum of forty (40) hours per week within a U.S. Public Health Service designated primary care (or mental health) Health Professional Shortage Area (HPSA), a facility with an automatic HPSA designation or a Medically Underserved Area (MUA) or Medically Underserved Population (MUP) designated within the past four (4) years.

4. Such service shall commence no later than 90 days after I receive notification of approval by both the U.S. Citizenship and Immigration Services (USCIS) and the U.S. Department of Labor and shall continue for a period of at least three (3) years.

5. I agree to incorporate all the terms of this "J-1 Visa Waiver Affidavit and Agreement" into any and all employment agreements I enter pursuant to paragraph 3 (above).

6. I further agree that any employment agreement I enter pursuant to paragraph 3 (above) does not contain any provision which modifies or amends any of these terms of this "J-1 Visa Waiver Affidavit and Agreement".

7. I understand and agree that my medical care services rendered pursuant to paragraph 3 (above) shall be in a Medicare and Medicaid certified site that has an open, non-discriminatory admissions policy. If my practice site is located in a federally designated low-income HPSA, that practice site will use a sliding fee scale for low-income, medically indigent patients.

8. I understand that this waiver must ultimately be approved by the USCIS, and I agree to provide written notification of the specific location and nature of my practice to the Kansas Department of Health and Environment at the time that I commence rendering services and will notify the Kansas Department of Health and Environment of any change in the location and nature of my practice within three (3) working days of the change or prior to the change.

9. I understand and acknowledge that if I willfully fail to comply with the terms of this J-1 Visa Waiver Affidavit and Agreement with the Kansas Department of Health and Environment may notify the U.S. Department of State and U.S. Citizenship and Immigration Services. Additionally, any and all other measures available to the Kansas Department of Health and Environment may be taken in the event of non-compliance.

I declare under the penalties of perjury that the information provided to the Kansas Department of Health and Environment for purposes of determining whether it will act in its capacity as state department of health is true and correct.

_____ _____

Signature Date

Subscribed and sworn to before me
this_____ day of _____, 20____

Notary Signature: _____

Notary Seal

Section 5:
DS-2019 Forms

Section 6:
U.S. Department of State Employer Attestation Form

Kansas Department of Health and Environment
Community Health Systems

Kansas Department of Health and Environment
J-1 Visa Waiver Program

U.S. DEPARTMENT OF STATE
EMPLOYER ATTESTATION

I, _____ hereby declare, under penalty

and provisions of 18 U.S.C.§ 1001, that _____,
(Employer Facility)
is located in a primary care or mental health care Health Professional Shortage Area (HPSA),

I.D. #_____, Zip Code _____

and provides financial assistance for medical care to both Medicaid and Medicare eligible

patients, including indigent and uninsured patients.

EMPLOYER SIGNATURE

_____ _____
Signature Date

NOTARY

Subscribed and sworn to before me this_____ day of_____, 20____.

Notary Signature: _____

Notary Seal

Section 7:
Physician’s Statement

Section 8:
Physician’s Current Curriculum Vitae

Section 9:
Explanation For Out of Status

Section 10:
Form G-28 or Letterhead from Law Office

Section 11:
I-94 Entry and Departure Cards

Section 12:
“No Objection” Statement

Section 13:
U.S Department of State
Exchange Visitor Attestation Form

Kansas
Department of Health and Environment

U. S. DEPARTMENT OF STATE

EXCHANGE VISITOR ATTESTATION

I, (*please print*) _____ hereby declare and certify, under penalty of the provisions of 18 U.S.C. 1001, that I do not have pending, nor am I submitting during the pendency of this request, another request to any United States Government department or agency or any other State Department of Public Health, or equivalent, other than the ***Kansas Department of Health and Environment***, to act on my behalf in any matter relating to a waiver of my two-year home-country physical-presence requirement.

_____ _____
Signature Date

Subscribed and sworn to before me
this_____ day of_____, 20____.
Notary Public

KDHE Division of Health
Bureau of Community Health Systems
Curtis State Office Building, 1000 SW Jackson St. Ste. 340, Topeka KS 66612-1365
Voice 785-296-1200 Fax 785-296-1231 http://www.kdheks.gov/olrh/index.html

Section 14:

Physician’s KS Board of Healing Arts Medical license

Section 15:
Physician’s ECFMG certification

Section 16:
Recruitment Documentation

Section 17:
Signed Community Support Statements

Kansas Department of Health and Environment
J-1 Visa Waiver Program

COMMUNITY STATEMENT OF SUPPORT

On behalf of _____ I am writing in support of the
(Organization/Group/Entity represented)

Kansas Department of Health and Environment's approval and granting of a J-1 Visa Waiver for

_____. It is my understanding
(Physician's First and Last Name)

that Dr. _____ will be employed by_____
(Physician's Last Name) (Employer Name)

to provide _____care, serving residents/community of
(Discipline/Specialty)

_____
(Description of Primary Service Area – County or Region of Kansas)

where these services are difficult to access.

I/My organization supports Dr. _____ and _____
(Physician's Last Name) (Employer Name)

efforts to address the unmet needs of our community, especially our low-income, and medically indigent patients and persons covered by Medicare and Medicaid.

SIGNATURE

_____ _____
Signature Date

_____ _____
Printed Name Title

Section 18:
Financial Assistance Policy, Sliding Fee Schedule, and Application Documents